Medication List

Name: --

Date: --

Please list:

Medications you are taking	Medications you are allergic to

Sign:--

PATIENT HEALTH FORM

Date____________Social Security #____________________Last dental exam_____________

Name______________________________________E-Mail ___________________________

Date of Birth__________________Age_______Sex____________

Address_________________________Apt#____City _________________St____Zip_____

Married_____Single______Widowed______Divorced______

Home Phone (_____)_______________ Cell Phone (_____)______________

Place of Business__________________________Business Phone (____)_____________

Spouse's name__________________Business phone (_____)______________

Has your Dental Insurance Co changed since your last visit? Yes / No

Referred By___________________________________

General Health: excellent____ good____ fair____poor____
Physician's name__________________________________
Have you ever been treated for periodontal disease?_________________

Please circle if you have ever been treated for any of the following:

heart disease	mitral valve prolapse	tuberculosis
rheumatic fever	heart murmur	lung disease
high blood pressure	jaundice	diabetes
low blood pressure	asthma	epilepsy
ulcers	sinus trouble	congenital heart lesions
cancer	hepatitis	hay fever
stroke	glaucoma	anemia
HIV	arthritis	bad breath
	joint replacement	

Do you have a pacemaker ? Yes ___ No ____
Have you had a joint implant, heart valve replacement or taken Phen Fen? Yes___ No ____
Are you subject to prolonged bleeding?______ fainting spells?______excessive thirst?_______
excessive urination?_____
Females: Are you pregnant?______ Doctors name____________________________
How often do you brush your teeth?__________floss?_________Do Your gums bleed?________
Do you feel pain when your teeth come in contact with certain foods?__________
Do you gag easily?___________ Do you grind your teeth?__________
Please add anything that you feel is important for us to know.

SIGN:____